that maintain societal equilibrium disappear. The theme of liquid societies was later picked up by Paolo Bertrando in an invited dialogue with Maria Borsca, where he talked about the current context of individualism, neo liberalism, and social Darwinism whilst noting liquidity in relation to family structures, social services structures and so on. Maria and Paolo talked about the need to adjust but not predict by being aware of one's feelings, one's position and one's interconnections.

The European association's structure has three chambers, national organisations (NFTO), training organisations (TIC) and individual members (CIN). At the general assembly, there were new elections for post holders for the next three years. David Amias was convincingly re-elected on the national associations board and will therefore also continue to be on the overarching European board. Monica Whyte from Ireland was elected as chair. She may be known to some of you from last year's AFT conference in Manchester when she was the national organisation's chair. It is good to have these strong links with our colleagues in Europe.

There were an impressive 69 posters of research and practice on display. A panel of judges selected awards based on creativity, scientific approach, innovation, artistry and an overall winner. The topics ranged from an analysis of Kahlo and Riviera's marriage, Kafka's letters to his father (balancing power in the father/son relationship) to the effectiveness of emotionally focused training in Hungary.

The workshops were held mainly on the two days we were at the university. These were two very long days, continuing well into the evening. There was a great variety and so many choices to make. These two days were flanked either side by two half days of presentations from keynote speakers.

It was great to see a number of people from the UK presenting, such as Arlene Healey and Gwyn Daniel providing a keynote session; and invited speakers included Reenee Singh and Desa Markovic. Workshops were presented by, Percy Aggett, David Amias, Ged Smith, Sarah Helps, Inga Britt-Krause, Philip Messent, Sharon Pettle, Chiara Sartin, Michelle Newman Brown, Máire Stedman and Peter Stratton.

Spending this time with all of our European colleagues and strengthening our connections seemed especially important during these 'liquid times' in the UK.

Nightmares and trauma *reprocessing*

Dzmitry Karpuk, Tom Stoneham and Robert Davies

About our collaboration

Our research originates in a collaboration between Tom Stoneham (professor of philosophy and dean of graduate research, University of York) and Dzmitry Karpuk (systemic family psychotherapist, Complex Trauma Therapists' Network, UK). Dzmitry has developed a novel method for reprocessing trauma-related nightmares and associated symptoms called 'systemic experiential embodied reprocessing' (SEER). Tom has developed the cultural-social model of dreams, which explains how it could work. Robert Davies (research associate, University of York) works on memory, including trauma memory, and related phenomena. We work on a number of projects together: designing continuing professional development training and conducting original research. We are writing a textbook for therapists working with nightmares.

Do we really know how to work with nightmares?

In 2017, we ran an online survey investigating therapists' experiences of working with nightmares and sleep disorders. The findings confirmed our suspicions. Of 146 therapists, the overwhelming majority of respondents (83.4%) had clients who presented with nightmares and sleep disturbances, but only 19.3% felt their formal training provided a good theoretical framework and appropriate interventions for working with these symptoms. Furthermore, 78% of respondents agreed that nightmares and sleep disturbances are commonly associated with bodily experiences (e.g. pain, tension, and uncomfortable sensations), but few had the confidence to integrate these experiences into their therapies.

Perhaps this lack of confidence results from too few therapeutic approaches having their own theory of dreams, or even preferred ways of working with them (Androutsopolou, 2011). Yet, the fact that nightmares and related symptoms are commonly associated with post-traumatic stress disorder and its complex version means that supporting trauma survivors simply forces us to work with these sleep disorders (Aurora *et al.*, 2010).

Our training events on nightmares and trauma have reached more than 250 therapists to date, with many participants supporting other therapists through clinical supervision. We continue to look at new ways to improve knowledge and skills in these areas.

Challenging paradigms and the cultural-social model of dreams

Nightmares are *bad* or *disturbing* dreams, and one difficulty for working with nightmares is that we have long-assumed we understand *dreaming*. The standard view – so prevalent in western culture that it is rarely questioned – sees dreaming as a private, psychological, and 'pseudo-perceptual' experience that occurs during sleep. *Dreaming* (like genuine perceptual experience) is thought to be encoded into memory, becoming *more-or-less* available for conscious recall on waking. In the context of therapy, this view places an explicit focus on the *dream narratives* because that is our only access to the cause of the dream: thus, the way to treat a dream on this view is for the dreamer to recount the narrative and for the therapist (or client, or both) to interpret it. This approach to dreamwork has, likewise, rarely been challenged.

Tom's research shows there are practical and theoretical problems with the standard view. Practically speaking, views about dreams vary dramatically across cultures, and requiring that clients divulge their nightmares for treatment is not always acceptable. More generally, dealing with trauma content is a sensitive matter. In our 2019 survey, 92.7% of respondents thought the re-telling of traumatic content can be *counter-therapeutic* if the timing or context is inappropriate; and two-thirds agreed that exploring traumatic content could be damaging or distressing for the

From narrative to embodied

Dzmitry Karpuk

Tom Stoneham

Robert Davies

client. There are documented connections between narrative interventions and client dropout (Imel *et al.*, 2013), and likely connections between re-telling trauma narrative and the risk of re-traumatisation (nearly one-third of our 2019 participants had clients become re-traumatised when discussing their nightmares).

The standard view of dreaming also doesn't easily explain some familiar sleep phenomena such as pre-cognitive dreams (Freud, 1913); the incorporation of nocturnal perception and interoception into dreams; and how alcohol, drugs, or even common foods such as cheese, can cause bad dreams. Furthermore, reported dreams follow patterns reflecting the culture of the dreamer and vary with the social context of the dream report.

Tom's cultural-social model (Fig. 1 in the poster) doesn't face these challenges. Cultural differences, societal expectations, bodily sensations, somnolent perceptions, and real memories of life events, are all key elements in the construction of dream narrative, a process that occurs primarily as we wake up. On this model, dreams aren't the products of a mysterious pseudo-perceptual process, thought to occur during sleep, but a combination of many factors – including expectations about what our dreams are meant to be like – that are sometimes weaved into a rich narrative in a complex social situation and a specific cultural context (Stoneham, 2019).

Dreams, then, are not the same as fixed memories or past events about which we can make accurate (or inaccurate) reports. Our relation to the objects and people in our dreams can be fluid and changeable, much like it can be in waking life. From this perspective, the dream narrative becomes less important as a focus for therapy. Adopting this view of dreams opens up new therapeutic options for dreamwork.

The 'SEER' method

One of key aims in developing this method has been addressing high dropout rates related to narrative-focused therapies. People process information in different ways – verbally, visually, kinaesthetically – but processing embodied experiences is a safer starting point in trauma recovery. The method was developed as a set of interventions for working with multiple and complex traumas using embodied reprocessing to minimise the risk of re-traumatisation. When combined with the cultural–social model of dreams, the approach shifts the therapeutic focus from stories of nightmares to the physiological symptoms that commonly occur with them.

SEER has a number of innovative features (Fig. 2 in the poster). One is that clients are never required to reveal the nightmare narrative. Instead, the method focuses on emotionally neutral descriptions of dream objects and developing a client's bodily awareness, and clients are taught to locate and externalise their traumatic embodied experiences. The focus is on current reactions and bodily sensations that are associated with various components (dream objects or people), and the therapist facilitates an internal dialogue with these sensations and experiences. The reprocessing occurs in the 'here and now' (Herman, 1992), and uniquely provides a way to utilise the pre-reflective and preverbal reactions of the body towards a certain situation.

The method encourages the therapist to take time developing clients' external and internal safety by utilising a scaffolding concept (Step 1), with the main focus on improving relationships between trauma survivors and significant others, including professionals. This work includes improving the relationship between

NIGHTMARES AND TRAUMA: A NON-NARRATIVE INTERVENTION*

STANDARD MODEL OF DREAMING

The 'Standard model' (SM) of dreaming is explicitly assumed in the cognitive sciences, and implicitly in a number of approaches to psychotherapy. But a number of famililiar phenomena do not fit with SM:

- Dream compression
- Pre-cognitive dreams
- Interference from perception/interoception

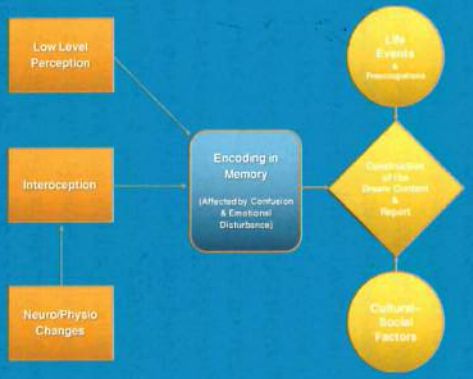

Figure 1: The Cultural–Social Model of Dreams

DREAMS WITHOUT DREAMING

The Cultural–Social model (CSM) of dreams (Fig. 1) is an alternative to the Standard Model, and can better explain the familiar phenomena above by drawing a distinction between 'dreaming' (a purportedly quasi-perceptal experience occuring during sleep) and 'dreams' (the waking experience of reporting a sequence of cognitions). On CSM, dreams are constructions prompted by confused memories of *actual* perception and interoception during sleep.

NON-NARRATIVE INTERVENTIONS

Assuming SM is correct makes it difficult to see how non-narrative interventions for the treatment of nightmares could work: treating nightmares ordinarily proceeds via the re-telling of the nightmare narrative. CSM makes an expanded range of clinical interventions possible because the dream narrative is constructed upon reporting and is thus affected by the social context of the report.

SAMPLE CASE STUDY

"My client C is in his late 20s and has had 8 sessions of talking therapy On his 7th session (just after the training) he was very unsettled about a [recurring] dream he had the night before. He started to talk through the dream and was getting distressed (was visually distressed about the dream ... he was reliving it).

My person-centred self would have stayed with the distress (what that meant for him) but [using the non-narrative method instead ...] he said 'I feel free'. He had a visual release.

This is a young man who has had panic attacks for nine years. (Would not even sleep on his side in case it put pressure on his heart.) He is now looking at next steps to move forward. (As a therapist I would have been stuck discussing the [dream narrative] and asking him about what it meant to him, etc. were it not for this method.)"

THE OBJECTIVE

Our objective is to support the integration of trauma-informed practices into systemic therapies, specifically focusing on embodied approaches to complex trauma therapy.

CHALLENGING PARADIGMS

The results challenge widespread assumptions about what dreams are and how they should be treated.

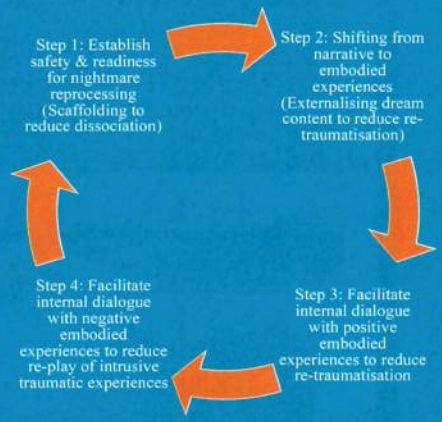

Figure 2: The SEER Method for Working with Nightmares

EMBODIED REPROCESSING

The integration of two theoretical views (phased trauma recovery and the Cultural–Social model of dreams) has allowed a shift in clinical perspective from narrative to Embodied Reprocessing. In Embodied Reprocessing we prioritise implicit memories or the long-lasting physiological impact of traumatic events instead of the narrative of these events. Embodied Reprocessing offers a possibility to include clients' physiological reactions into talking treatment.

THE METHOD

The SEER (Systemic Experiential Embodied Reprocessing) method (Fig. 2) was designed in response to a limited choice of trauma-recovery therapies where the systemic approach is applied to trauma-informed interventions. It makes use of 'embodied' rather than 'narrative' reprocessing and is designed to address high drop-out rate related to re-traumatisation. It aims to minimise re-traumatisation and enables trauma survivors to process 'stack' experiences where narrative content is unavailable or carries significant risk.

THE COLLABORATION

Our collaboration supports the development of a training programme that delivers quick and effective training of therapeutic interventions underpinned by up-to-date research on dreams and dreaming.

THE TRAINING

The training demonstrates how clients can process traumatic material without revealing potentially re-traumatising nightmare content.

SAMPLE TESTIMONIAL

"I feel much more competant working with clients presenting with dreams. This framework and training gives a foundation of understanding and you can provide a better service. It could be part of degree or college courses. I feel more competant as a therapist."

TESTING EFFECTIVENESS

In-depth, semi-structured interviews with clinicians using the method reveal strikingly high levels of satisfaction and strong testimonial evidence for the method's effectiveness.

PRELIMINARY RESULTS

All interviewees to date ($n = 16$) were satisfied with the method. Interviews included reports of increased confidence, dramatic changes in clients' conditions, and delivered several informative case studies. The research is ongoing.

*THIS RESEARCH IS CONDUCTED BY PROFESSOR TOM STONEHAM (UNIVERSITY OF YORK), DZMITRY KARPUK (CTTN, UK), AND DR ROBERT A DAVIES (UNIVERSITY OF YORK).

the clients' negative thoughts and their alienated physiological reactions (bodily symptoms), sometimes called the body–mind connection (van der Kolk, 2014). Clients are then supported in changing focus from narrative interpretation of their dreams to alienated bodily sensations and experiences (Step 2). This is an important part of continuing development of bodily awareness where we support clients to avoid focusing on feelings and emotions at this time of nightmare reprocessing. At this stage, clients are helped to externalise their internalised traumatic embodied experiences, often by utilising a body map of all traumatic embodied experiences.

In Steps 3 and 4 the client accesses previously avoided bodily experiences (bodily memories) while staying in the window of tolerance (Siegal, 1999) to create an internal dialogue with these sensations and experiences. This process avoids the rehearsing of painful narratives which can re-traumatise clients.

The method specifically focuses on re-evaluation and re-authoring embodied reports related to nightmares, but not the dream report itself. These re-authorings are achieved by reprocessing embodied experiences and thoughts at the time when trauma clients have learnt to externalise their painful feelings and emotions.

References

Androutsopolou, A. (2011) Red balloon: Approaching dreams as self-narratives. *Journal of Marital and Family Therapy*, 37(4): 479-490.

Aurora, R.N, Zak, R.S., Auerbach, S.H., Casey, K.R., Chowduri, S., Krippot, A., Maganti, R.K, Ramar, K., Kristo, D.A., Bista, S.R., Lamm, C.I. & Morgenthaler, T.I. (2010) Best practice guide for the treatment of nightmare disorders in adults. *Journal of Clinical Sleep Medicine*, 6(4): 389-401.

Freud, S. (1913) *The Interpretation of Dreams*. New York: Macmillan.

Herman, J. (1992) *Trauma and Recovery*. New York, NY: Basic Books.

Imel, Z.E., Laska, K., Jakupcak, M. & Simpson, T.L. (2013) Meta-analysis of dropout in treatments for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 81(3): 394-494.

Siegel, D.J. (1999) *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are*. New York: Guilford Press.

Stoneham, T. (2019) Dreaming, phenomenal character, and acquaintance. In: J. Knowles & T. Raleigh (eds.) *Acquaintance: New Essays* (pp. 145-168). Oxford: Oxford University Press.

van der Kolk, B. (2014) *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. New York, NY: Penguin Books.

Annie thinks about ways of staying connected and maintaining confidence

Who is Annie from Aspens?

Annie is a virtual systemic psychotherapist of no specific gender or cultural heritage working somewhere in the UK. She/he is working in independent practice and discovering new challenges. Aspens has, over many years now, been developing a support network for systemic psychotherapists working in independent practice, initially using a Google group as a way of connecting practitioners with each other. The concept of Annie developed during an online Aspens discussion and, through Annie, we have an opportunity to explore issues and dilemmas of working independently. Any similarity to anyone you might know is purely accidental, apart from the fact that Annie shares experiences that many of us have faced. Through conversations with Annie we hope you might find some new and useful ideas.

Reporter: Hi Annie.... what have you been thinking about in recent weeks?
Annie: I have been pondering several questions about independent practice, especially around the issue of how practitioners might access support, be that clinical, emotional or practical support. Being self-employed has many benefits, but I am curious about how therapists maintain confidence in their practice and counter the potential for isolation.
Reporter: What have you done with these questions?
Annie: Well, I have canvassed independent practitioners for their views and would like to share some of their ideas with you. Whilst clinical supervision underpins systemic practice whatever the context, independent practitioners have needed, and have found, many additional mechanisms to support both their therapeutic practice and also the wider demands of working as an independent practitioner. Developing a sustainable practice and learning a new range of skills can take time and may well need refining and developing as circumstances change. What is clear from the responses is that each therapist's situation and plan for support is unique, but it is a process that for many has been achieved through trial and error. The aim of these articles is to share knowledge and experience so as to support this process. Building a sustainable practice in any field of self-employment can take years, and some changes such as relocation of a family home might require re-establishing a practice in a new location and again take considerable time, thought and effort.

Some therapists began their preparations before leaving an employed post; for example, by doing a supervisors course. Financial preparation also featured in the responses. Many therapists begin independent practice following retirement and often rely on a pension to support their independent practice especially, but not only, in the early days. Many therapists have developed a portfolio of different types of income generation to support their therapy practice over the long term. Needing support with invoicing and tax returns is daunting for some therapists.

Many therapists would have had long professional careers where sharing and